STATE HEALTH BENEFITS PROGRAM
COBRA BENEFITS CONTINUATION SCHEDULE
RATES EFFECTIVE 1/1/05 - 12/31/05

Attached are the monthly premium rates for continued coverage under the State Health Benefits Program (SHBP) COBRA Program effective January 1, 2005 to December 31, 2005. To determine your premium:

1. Locate in the left hand column the coverage(s) in which you wish to be enrolled. If you are eligible for health coverage, you may elect any health plan that serves the area in which you live and for which you are eligible to enroll. If you are eligible for dental coverage, you may elect any dental plan that serves the area in which you live.
2. Once you have identified the plan you desire, select the Contract Type you wish to elect. **YOU MAY NOT ELECT A CONTRACT TYPE WHICH EXCEEDS THAT WHICH YOU HAD ON THE LAST DATE PRIOR TO THE TERMINATION OF YOUR HEALTH CARE COVERAGE.** You may elect the same or a lesser level of coverage. For example, if you had member and spouse coverage as an active employee, you could elect member and spouse or single coverage under COBRA. You could not elect family or parent-child coverage (unless an event occurs during the election period - marriage, birth, etc.). **You may not elect Dental, Vision, or Prescription Drug coverages unless you were enrolled in that coverage on the date of the COBRA event making you eligible for enrollment in the program.**
3. On the COBRA Application, check the box associated with the Plan and Contract Type elected. **If you are electing NJ PLUS or HMO coverage, be sure to list the name and physician ID number of the NJ PLUS or HMO Primary Care Physician. If you are electing dental coverage, be sure to specify the plan in which you wish to enroll. If you are selecting a Dental Plan Organization (DPO), you must indicate a Primary Dental Facility or dentist.**

Forward your completed COBRA application without premiums to:

Division of Pensions & Benefits
COBRA Section
PO Box 299
Trenton, NJ 08625-0299

Once your COBRA application has been processed, the SHBP will bill you for premiums you owe for continued coverage. You will be billed on a monthly basis, however your first bill may include an additional billing of retroactive premiums due. Premiums should be sent to:

State of New Jersey
State Health Benefits Program
Newark Post Office
PO Box 19519
Newark, NJ 07195-0519

To contact the SHBP regarding COBRA, please write, or call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524. You may also reach us by e-mail at: pensions.nj@treas.state.nj.us

HC-0727-0904p

COBRA RATES

(STATE EMPLOYERS)

For employees not subject to plan revisions*

Rates Effective January 1, 2005 to December 31, 2005

COVERAGE	TYPE OF CONTRACT			
	Single	**Member & Spouse/ Domestic Partner**	**Family**	**Parent & Child**
NJ PLUS – #001	$ 308.19	$ 671.75	$ 799.54	$ 463.65
Traditional Plan – #002	$ 507.31	$ 1,085.80	$1,292.28	$ 749.33
HMO Plans:				
Aetna Health – #019	$ 295.54	$ 652.69	$ 759.13	$ 436.39
CIGNA HealthCare – #020	$ 353.25	$ 770.54	$ 919.00	$ 530.25
Oxford Health Plan – #028	$ 321.13	$ 706.42	$ 834.85	$ 481.71
AmeriHealth HMO – #033	$ 330.49	$ 735.36	$ 856.39	$ 487.90
Health Net – #034	$ 360.34	$ 784.96	$ 952.88	$ 552.77
STATE PRESCRIPTION DRUG PLAN	$ 115.11	$ 263.10	$ 276.35	$ 153.64
DENTAL RATES				
Dental Expense Plan – #399	$ 40.73	$ 70.78	$ 115.83	$ 85.80
Dental Provider Organizations (DPOs):				
Atlantic Southern Dental (BeneCare)-#301	$ 23.65	$ 41.09	$ 67.24	$ 49.81
Community Dental Associates – #302	$ 22.57	$ 39.23	$ 64.18	$ 47.54
CIGNA Dental Health, Inc. – #305	$ 20.58	$ 35.79	$ 58.54	$ 43.39
Group Dental Health Administrators – #306	$ 20.48	$ 35.57	$ 58.22	$ 43.13
Healthplex (Internat'l Heath Care Svc.)– #307	$ 20.09	$ 34.91	$ 57.13	$ 42.31
Fortis Benefits (Protective/Oracare) – #308	$ 20.09	$ 34.91	$ 57.13	$ 42.31
Flagship Health Systems, Inc. – #312	$ 20.09	$ 34.91	$ 57.13	$ 42.31
Dental Group of New Jersey – #314	$ 18.77	$ 32.66	$ 53.40	$ 39.57
Horizon Dental Choice – #317	$ 20.09	$ 34.91	$ 57.13	$ 42.31
Aetna DMO – #319	$ 19.49	$ 33.90	$ 55.45	$ 41.09
VISION CARE	$ 0.55	$ 1.16	$ 1.59	$ 0.87

* Traditional Plan deductible $100, NJ PLUS and HMO office visit copayment $5.
Prescription Drug Plan copayment $1 for generic drug, $5 for name brand drug.